Yale NewHaven Health

Your 2021 Health Care Benefits Connection

Westerly Hospital

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2021 Open Enrollment

Enroll October 26–November 6, 5 p.m. ET

New year. A new medical plan.

No deductibles. No coinsurance. Just copays when you use our Signature providers.

Open enrollment is your once-a-year opportunity to make changes to your benefits so they continue to be the right fit for you and your family. Outside of experiencing a qualifying life event, it's the only time you can change plans or add or remove dependents.

Please take a moment to review what's new and changing for 2021—in particular, the new medical plan option and new Signature provider network you'll have beginning January 1 if you elect the YNHHS Medical Plan. You'll also find minor changes to other plans. It's important that you understand all these changes and what they mean for you going forward.

If you don't enroll by 5 p.m. ET on November 6:

- You will not have a Health Care or Dependent Care Flexible Spending Account for 2021.
- You will be unable to contribute to the Health Savings Account in 2021.
- If you're currently enrolled in one of the High-Deductible Health Plans, you and any dependents you currently cover will automatically be enrolled in the same plan for 2021. If you're currently enrolled in one of the YNHHS Advantage PPO Plans, you and any dependents you currently cover will automatically be enrolled in the new YNHHS Medical Plan and in living**wellCARES**.
- You and any dependents currently on your plan will have the same dental and vision coverage for 2021.
- If you waived coverage for 2020, your coverage will be waived for 2021.

Enrollment questions?

HRConnect has the answers.
Call Monday–Friday, 7:30 a.m.–5 p.m. ET
844-543-2147
Enroll now: ynhhsbenefits.com

What You Need to Know

The new Benefits Connection website (ynhhsbenefitsconnection.org) replaces the Benefit Summary Blue Book you've received every year to guide your enrollment decisions. It's designed to provide easily accessible benefits information to you and your family, wherever you are, whenever you need it—via smartphone, tablet, or desktop. Just tap on the active links embedded in the content to take action or find more information. Be sure to save it to your favorites so it's handy!

Even better, the site links you directly to bswift, your enrollment site. It's also mobile-optimized, so you can enroll from your phone, tablet, or desktop.

What's New and Changing for 2021

The Medical Plan. Beginning January 1, the new YNHHS Medical Plan replaces the Advantage and Advantage Plus Medical Plans. It is offered in addition to the High-Deductible Health Plan with Health Savings Account or Health Reimbursement Account. The YNHHS Medical Plan connects you to the world-class care our facilities and affiliated physicians offer at reduced copays. You can also choose to get care through the Anthem Century Preferred Network or from out-of-network providers.

Under the new plan:

- You'll pay less for care when you use YNHHS providers and facilities in the Signature network. You'll pay no deductible or coinsurance—just copays.
- If you choose to use an Anthem network provider, you'll first have to meet a $3,500 (individual)/$7,000 (family) deductible before the plan begins to share some of the costs. After you meet your deductible, you'll pay a copay or coinsurance for services.
- You'll need to meet only one combined annual out-of-pocket maximum for medical and prescription drugs.

- **If you're enrolling in the new YNHHS Medical Plan,** you'll also be enrolled in the *living***wellCARES** care management program. During enrollment, you'll have the opportunity to opt out of this program.
- The Dependent Care and Health Care FSA administrator will change from PayFlex to HSA Bank beginning January 1, 2021.
- **Dependent Care FSA.** You have until December 31, 2020, to submit 2020 claims through PayFlex. After January 1, you will submit claims for 2021 expenses through HSA Bank.
- **Health Care FSA.** Up to $550 of unused funds will automatically roll into 2021. Claims for expenses incurred between now and **December 31, 2020**, should be submitted through **PayFlex by March 31, 2021**. After January 1, you will submit claims for 2021 expenses through HSA Bank. Your rollover funds, if applicable, will be available after April 1, 2021.

What You Need to Do

- Review this site for your medical, dental and vision plan options, and consider how your needs may be different for 2021.
- Add or remove dependents, as needed.
- Make your Dependent Care Flexible Spending Account and/or Health Care Flexible Spending Account contribution elections for 2021.
- Enroll to make your benefit elections for 2021. You can return to the enrollment site at any time to change your elections between October 26 and November 6 at 5 p.m. ET.
- Print a copy of your enrollment confirmation and keep it for your records.

Things to Keep In Mind

- Use your Dependent Care FSA funds by December 31 or you'll lose them.
- **If you have a Health Care FSA, you can roll over up to $550 for 2021**, but you'll forfeit any balance above that. Reminder: You have until March 31, 2021, to submit claims for 2020 through PayFlex.

- **Don't skimp on care.** Although you may be tempted to put off a doctor's visit, it's always better to get care sooner rather than later. Use your telehealth benefit [link to Urgent Care & Telehealth page] to get the care you need, when you need it—without leaving home.
- **Plan for the unexpected** by providing additional financial security for your family. Through YNHHS voluntary benefits, you can purchase group hospital indemnity insurance, group legal insurance, and group critical illness insurance at prices that are typically below market rates. You can also enroll in auto, home, or pet insurance, as well as identity theft protection any time of the year.
- **If you or your dependents have student loan debt,** you may want to consider the Common Bond Student Loan Refinancing program. It's a new offering for 2021.
- **It's a good idea to review your 403(b) and life insurance beneficiaries** every year, and make changes as needed.
- **If you participated in the Know Your Numbers Plus program** in 2020, you'll see your annual employee premium credit on your enrollment confirmation statement if you enroll in the YNHHS Medical Plan. If you did not participate this year or are a new hire, you'll be able to participate in 2021 to earn credit toward your 2022 medical premium.

If You Take No Action During Open Enrollment

- You will be unable to contribute to a Health Care or Dependent Care FSA or to the Health Savings Account (HSA) in 2021.
- You will receive no employer contributions to your HSA in 2021.
- You and any dependents you currently cover on your medical plan will be automatically enrolled in the new YNHHS Medical Plan if you're currently covered by one of the Advantage Medical Plans. If you're covered by one of the HDHPs, you and any dependents on your plan will be automatically enrolled in that plan for 2021.
- You and any dependents you currently cover (if eligible) will be automatically enrolled in the same dental and vision plans you had in 2020.
- If you waived plan coverage in 2020, your coverage will remain waived in 2021.

Eligibility

WHAT YOU NEED TO KNOW

If you're eligible for benefits, you can enroll yourself, your spouse or domestic partner, and/or your dependent children in medical, prescription drug, dental, and vision coverage—plus other voluntary and financial benefits. Your benefits are effective on your first day of employment or first of the month following 30 days if your status changes to benefits-eligible. Who's Eligible for Coverage

Who's Eligible for Coverage

You're eligible for benefits if you're a regular, full-time employee (36 or more hours per week) or a benefits-eligible part-time employee (generally 24–35 hours per week) of Westerly Hospital. **Note:** Under the YNHHS Medical Plan, eligibility is a minimum of 24 hours per week, and domestic partners are not covered.

If you're eligible, you can also enroll:

- Your legal spouse
- Your domestic partner (in the HDHP Medical Plan only)
- Your dependent children under age 26:
  - Biological children
  - Stepchildren
  - Adopted children, including those placed for adoption
  - Foster children
  - Any children for whom you are responsible per a court order
- Your dependent children over age 26, if fully dependent on you for support due to a disability and covered by you prior to age 26

Supporting documentation required for dependents

To enroll your dependents, you'll need to provide applicable supporting documentation such as a marriage certificate, birth certificate, court order, or federal income tax return. For details, visit HRConnect.

Coverage Under Multiple Plans (YNHHS Medical Plan only)

If you are enrolled in the YNHHS Medical Plan and you or members of your family are covered under more than one medical plan, your plan coordinates benefits to prevent duplication and overpayment of benefits. Here's how that works:

When you (the employee) are the patient

Your plan will be the first to pay benefits. After you submit a claim, the other plan will then pay benefits according to its policies.

When your spouse/partner is the patient

His/her plan will pay benefits first. Then, your plan will pay its normal benefits, minus any benefits paid by your spouse/partner's plan. If his/her plan pays benefits that are equal to or greater than the benefits your plan would otherwise pay, your plan will not pay benefits.

When your child is the patient and he or she is covered by your plan and your spouse/partner's plan

The dates of your and your spouse/partner's birthday will drive which plan pays benefits first. The plan of the person whose birthday occurs earlier in the year will pay benefits first. If your plan pays benefits second, its normal benefit will be reduced by the amount paid by the other plan.

Connect with…

HRConnect
Monday–Friday, 7:30 a.m. to 5 p.m. ET
844-543-2147
203-200-3838 (fax)

Enrollment

WHAT YOU NEED TO KNOW

As a new employee, you must enroll in benefits within 30 days, or you and your dependents will have no medical, prescription drug, dental, or vision coverage. You'll have to wait until the next open enrollment period to elect these benefits, unless you experience a qualifying life event.

Don't forget—you'll need supporting documentation to enroll your dependents.

When to Enroll

Enroll for the following benefits within 30 days of your first day on the job, during the annual open enrollment period, or within 31 days of experiencing a qualifying life event:

- Medical coverage
- Prescription drug coverage
- Dental coverage
- Vision coverage
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Limited Purpose Health Care Flexible Spending Account (HDHP Medical Plan only)
- Group legal plan (voluntary benefit)
- Hospital indemnity coverage (voluntary benefit)
- Group critical illness insurance (voluntary benefit)

As a new employee, you're automatically enrolled in the 401(k) plan.

Enroll at any time for:

- Auto and home insurance (voluntary benefit)
- Pet insurance (voluntary benefit)
- Identity protection (voluntary benefit)
- Student Loan Refinancing Program (voluntary benefit)

Learn more about the voluntary benefits you can choose. To enroll, call **866-874-2837** or visit the voluntary benefits website.

When Changes Are Allowed

After you enroll, you can make changes only during annual open enrollment or within 31 days of experiencing a qualifying life event:

- Marriage
- Divorce
- Childbirth/adoption
- Coverage loss or gain

You must submit documentation that supports the event.

How to Enroll

To enroll or make changes to your benefits, visit bswift (http://www.ynhhsbenefits.com/), our secure, online enrollment website. You'll be prompted to enter your YNHHS username and password. If you run into problems, call HRConnect at **844-543-2147**.

Need more info first? You'll find details at HRConnect.

Yale New Haven Health System (YNHHS) Medical Plan

YNHHS Medical Plan—**New Plan for 2021!**

WHAT YOU NEED TO KNOW

New for 2021, the YNHHS Medical Plan connects you to the world-class care provided by our new Signature networks of facilities and providers. Of course, you can also use Anthem PPO or out-of-network providers, but you'll usually pay more if you do. The medical plan is administered by Anthem Blue Cross and Blue Shield.

Connect with YNHHS Provider

The Signature network includes: YNHHS facilities/hospitals, PCP's from NEMG, Community Medical Group (CMG), Yale Medicine (YM), WestMed in CT, Trinity Health of New England hospitals and affiliated physicians. Also included are specialists from YM, NEMG, CMG and Trinity Health, and those credentialed at YNHHS.

How the Plan Works

The new YNHHS Medical Plan is designed to help keep you and your family healthy. Used in tandem with your other benefits—including care and condition management and coaching services—it's here to support you when you need care.

- You'll pay nothing for preventive care—including some preventive tests and prescription medications—when you use network providers.
- If you choose to use an Anthem network provider, you'll first have to meet a $3,500 (individual)/$7,000 (family) deductible before the plan begins to share costs. After you meet your deductible, you'll pay a copay or coinsurance for services.
- Behavioral health and substance abuse benefits are included in the medical plan.
- You only need to meet one combined annual out-of-pocket maximum for medical and prescription drugs. All your copays and coinsurance for covered services are applied toward this maximum. Once the out-of-pocket maximum is met, the plan pays 100% of eligible expenses for the remainder of the calendar year for each enrolled person.
- Special rules apply when you or your covered dependents are covered by more than one plan.

You may choose to waive medical coverage if you're covered by another plan or your spouse is a YNHHS employee.

How much you pay for care depends on the provider or facility you choose:

Signature Network—YNHHS Facilities & Providers

When you use a Signature network provider and facility, you'll pay less for covered services. You pay a flat copay for care and do not have to pay a deductible before the plan begins to pay benefits.

Note: Some Signature Network providers also provide care at facilities that are not in our health system. If you receive care at these other sites, you will pay higher costs for these facilities. For example, a surgeon who practices at Signature network facilities may also perform surgery at private surgical centers. If your surgery is done at a private center, you would pay the Anthem PPO network or Out-Of-Network rate for the doctor and the facility.

- You'll generally pay a flat copay for care when you use Signature network providers and facilities, including:
    - Facilities owned by Yale New Haven Health and Trinity New England
    - Our Signature Clinician network of Signature primary care providers and specialists who are credentialed at a facility owned by Yale New Haven Health
    - For a complete list of the Signature network providers, visit HRConnect.
- Once you meet your annual out-of-pocket maximum, the plan will pay 100% of covered expenses through that calendar year.

Anthem PPO Providers

When you choose to receive care from an Anthem Century Preferred Network provider:

- You'll need to meet your annual deductible before the plan begins to share the cost of your care.
- After you meet your deductible, you'll generally pay 20% coinsurance or a copay until you reach your annual out-of-pocket maximum.
- Once you meet your annual out-of-pocket maximum, the plan will pay 100% of covered expenses through that calendar year.

To find a provider in the Anthem Century Preferred Network, visit the Anthem website (http://anthem.com/) or call **888-266-2896**.

Out-of-Network Providers

When you use a provider or facility that is not in the Signature or Anthem Century Preferred Network:

- You'll pay the most for care.
- Anthem will pay a maximum allowable amount (MAA) for covered services.
- You will be responsible for costs up to your annual deductible, coinsurance, and any difference between the MAA and the amount billed by the provider.
- You'll need to file a claim for the care to be covered. Payments will be made directly to the provider unless you submit a bill showing you've paid it already.

No-cost vaccines for you and your dependents

You and your covered dependents can get no-cost vaccines for shingles, pneumonia, flu (ages 18 and older only), tetanus/diphtheria, and hepatitis A and B through the CVS Caremark Broader Vaccination Network.

What You Pay for Care

Below is a summary of how certain services are covered. For a more complete list and any limitations, visit HRConnect to view the summary plan description (SPD), which will be available January 1, 2021.

To see employee premium contributions for the medical plan, visit the enrollment site.

Plan Feature	Signature Facility/ Provider	Anthem PPO Provider	Out-of-Network Provider
Annual Deductible	Individual: $0 Family: $0	Individual: $3,500 Family: $7,000	Individual: $10,000 Family: $20,000
Out-of-Pocket Maximum[1]	Individual: $3,000 Family: $6,000	Individual: $8,150 Family: $16,300	Individual: $30,000 Family: $60,000
Office Visits and Physician Services			
Primary Care Visit[2,3]	$10 copay	$30 copay	50% of MAA* after deductible
Specialist Office Visit[2]	$25 copay	$50 copay	50% of MAA* after deductible
Routine Adult Exam[2,4]	0%, no copay	0%, no copay	50% of MAA* after deductible
Doctor or Surgeon Services[5]	0%, $0 copay	20% after deductible	50% of MAA* after deductible
Allergy Shot in Doctor's Office (no MD visit)	$10 copay	$30 copay	50% of MAA* after deductible
Nutrition Counseling and Diabetes Self-Management Training	0%, no copay	0%, $0 copay	50% of MAA* after deductible
Women and Children			
Well-Woman Visit (OB/GYN preventive exam)[6]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Mammography[7] (including 3D and bone density test)	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Screening Breast Ultrasound (if dense breast tissue or a history)	$20 copay	$20 copay	50% of MAA* after deductible
Maternity Care[8] (initial visit)	$10 copay	$10 copay	50% of MAA* after deductible
Well-Baby/Well-Child Care[2,9]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Specialized Infant Formula	n/a	50% coinsurance	50% of MAA* after deductible
Infertility Services[10]	100% up to lifetime max with limits for certain services	50% up to lifetime max with limits for certain services	n/a
Ancillary Services			
Lab Services	$25 copay	20% after deductible	50% of MAA* after deductible

Plan Feature	Signature Facility/ Provider	Anthem PPO Provider	Out-of-Network Provider
Diagnostic Testing[11] (facility charges only)	$25 copay	20% after deductible	50% of MAA* after deductible
High-Tech Diagnostic Imaging[12] (facility charges only)	$100 copay	20% after deductible	50% of MAA* after deductible
Colorectal Cancer Screening[13]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Chiropractic Visits[14]	n/a	$30 copay	50% of MAA* after deductible
Physical and Occupational Therapy[14]	$10 copay	$30 copay	50% of MAA* after deductible
Speech Therapy[14]	$10 copay	$10 copay	50% of MAA* after deductible
Inpatient and Outpatient Care			
Inpatient Hospital Services[15]	$250 copay	20% after deductible	50% of MAA* after deductible
Outpatient Surgery[16]	$100	20% after deductible	50% of MAA* after deductible
Infusion and Radiation Therapy	$25 copay	20% after deductible	50% of MAA* after deductible
Behavioral Health and Substance Abuse			
Inpatient Treatment (facility charges only)	$250 copay	20% after deductible	50% of MAA* after deductible
Outpatient Treatment[17]	$10 copay	$10 copay	50% of MAA* after deductible
ABA Therapy[18]	n/a	$10 copay	50% of MAA* after deductible
Urgent and Emergency Care and Telehealth			
Emergency Department	$250 copay	$250 copay	$250 copay
Urgent Care Facility and Walk-In Medical Center	$25 copay	$50 copay	$50 copay
Ambulance	n/a	0% after deductible	0% after deductible
Telehealth	0%, $0 copay	$30 copay	Not covered
Non-Acute Care			
Skilled Nursing Facility[19]	20% coinsurance, no deductible	20% coinsurance, no deductible	50% of MAA* after deductible
Home Health Care[20]	20% coinsurance, no deductible	20% coinsurance, no deductible	50% of MAA* after deductible
Hospice Care[21]	n/a	20% coinsurance, no deductible	50% of MAA* after deductible
Other			
Durable Medical Equipment	n/a	20% coinsurance, no deductible	50% of MAA* after deductible

Plan Feature	Signature Facility/ Provider	Anthem PPO Provider	Out-of-Network Provider
Hearing Aids[22]	n/a	50% coinsurance, no deductible	50% of MAA* after deductible
Orthotics	n/a	50% coinsurance, no deductible	50% of MAA* after deductible

* Maximum allowable amount.

[1] Amounts paid toward care provided by all in-network providers accumulate toward both the YNHHS and Anthem PPO out-of-pocket maximums. However, when the YNHHS in-network out-of-pocket maximum has been reached, amounts paid for YNHHS in-network care no longer accrue toward the Anthem PPO out-of-pocket maximum. Amounts paid for Anthem PPO in-network care continue to accrue until the Anthem PPO out-of-pocket maximum is met.

[2] Tests (e.g., some lab work) that are associated with office visits may be subject to a copay or deductible and coinsurance if they are not mandated by the ACA. Check with your provider or call Anthem to determine if a specific test is covered at 100%.

[3] A list of Signature providers is posted to: http://ynhhs.org/hrconnect

[4] One exam every calendar year starting at age 22 (includes immunizations).

[5] Other than office visit; includes maternity claims.

[6] One per calendar year. All other OB/GYN office visits are covered at the specialist office visit benefit level.

[7] Screening mammography only. Does not include breast ultrasounds.

[8] Prenatal care and delivery. Well visits to the obstetric provider are billed with one global fee that includes trimester visits, delivery, and postpartum care. Any maternity-related tests that are needed, such as blood work, glucose tolerance tests, stress tests, ultrasounds, or amniocentesis, are billed separately. Inpatient hospital and doctor or surgeon services also apply.

[9] Seven exams from birth to age 1 year; seven exams from ages 1 to 5; one exam from ages 6 to 21.

[10] The plan covers in-network fertility services only through YNHHS and Anthem PPO providers. YNHHS providers: Yale Reproductive Endocrinology and Infertility (REI) Center and YNHHS Outpatient Pharmacy Services. 100% up to lifetime max of $14,000 for medical and freezing and transferring embryos, and 100% up to lifetime maximum of $2,000 for prescription drugs through the pharmacy benefit. Anthem PPO providers: 50% of covered medical services at a participating Anthem provider, plus covered prescription drugs at a participating CVS Caremark pharmacy, up to a combined lifetime maximum of $10,000.

[11] Includes x-rays, echo stress tests, ultrasounds, diagnostic mammograms, and EKGs. Patients will receive a bill for the reading of the diagnostic testing and imaging (covered under “Doctor or Surgeon Services”).

[12] PET, SPECT, MRI, MRA, CTA, and CAT.

[13] Diagnostic colonoscopies covered under the outpatient surgery benefit level. Includes fecal occult blood test, barium enema, flexible sigmoidoscopy, and screening colonoscopy.

[14] Chiropractic, physical therapy, occupational therapy, and speech therapy combined maximum: 50 visits per calendar year.

[15] Room and board, lab work, medical supplies, and other hospital ancillary services.

[16] Hospital or surgical center facility charges only.

[17] The Employee and Family Resources (EFR) program provides up to six (6) confidential counseling sessions at no cost.

[18] Applied behavioral analysis, up to age 21.

[19] Up to 120 days per calendar year after a hospital stay.

[20] Up to 120 days per calendar year.

[21] Up to 60 days per calendar year.

[22] Two hearing aids every 36 months.

Save With Signature Providers & Facilities

The following examples* show how using a Signature provider and facility can save you money. As a reminder, if you use a Signature provider but your care takes place in a facility that is not in our network, the facility expenses will be covered as Anthem or out-of-network care.

Example #1: Signature Savings

Tony saves $7,150 using a Signature provider and Signature facility for his knee surgery.

	YNHHS Signature Provider and Facility	Anthem PPO Provider & Facility
Facility Charge Allowed	$20,000	$20,000
Doctor or Surgeon Fees Allowed	$3,000	$3,000
Annual deductible (paid by Tony)	$0	$3,500
Amount Left to Pay	$23,000	$19,500
Tony's Cost after Deductible (including inpatient copay/coinsurance)	$250	20% = $3,900
Total Amount Plan Pays	$22,750	$15,600
Total Amount Tony Pays	$250	$3,900 + $3,500 = $7,400

Example #2: Signature Provider + Anthem Facility Costs

If Tony had the same procedure but it takes place in an Anthem facility, he will spend $6,550 more than in the first example.

	YNHHS Signature Provider	Anthem Facility
Facility Charge Allowed	N/A	$20,000
Doctor or Surgeon Fees Allowed	$3,000	N/A
Annual Deductible (paid by Tony)	$0	$3,500 (for Anthem facility)
Amount Left to Pay	$3,000	$16,500
Tony's Cost after Deductible (including inpatient coinsurance)	$0 owed for doctor or surgeon fees + 20% for facility = $3,300 ($16,500 x 20% = $3,300)	
Total Amount Plan Pays	$3,000	$16,500
Total Amount Tony Pays	$6,800 ($3,500 deductible + $3,300 coinsurance)	

Example #3: Anthem PPO Provider + Anthem Facility Costs

If Tony uses an Anthem provider and an Anthem facility, he will spend $600 more than in the second example.

	Anthem PPO Provider & Facility
Facility Charge Allowed	$20,000
Doctor or Surgeon Fees Allowed	$3,000
Annual deductible (paid by Tony)	$3,500
Amount Left to Pay	$19,500
Tony's Cost after Deductible (including inpatient copay/coinsurance)	20% = $3,900 ($19,500 x 20%)
Total Amount Plan Pays	$15,600
Total Amount Tony Pays	$3,900 + $3,500 = $7,400

*These examples are for illustrative purposes only. Your actual cost share may vary depending on the care you receive, the facility used, and specifics if you're admitted as an inpatient. These examples are not provided as a guarantee of coverage or an actual estimate of specific benefits under the plan.

When to Connect With Anthem

For a medical stay and/or service preauthorization, call 800-238-2227 (in Connecticut) or 800-248-2227 (out of state). For behavioral health or substance abuse stays, call 800-934-0331.

Before receiving any of these services, you must call Anthem for preauthorization. Otherwise, your benefits will be reduced.

- **Inpatient stays** in a hospital, skilled nursing facility, hospice facility, subacute care or acute rehabilitation facility, or behavioral health or substance abuse treatment center (call at least 24 hours before the start of your stay)
- **High-cost diagnostic imaging services** prescribed by an out-of-network provider
- **Organ/tissue transplants,** including evaluation, donor search, organ procurement/tissue harvest, or transplant

For admissions following emergency or urgent care, you, your representative, or your doctor must call Anthem within 48 hours of admission.

If you do not precertify for the services above:

- Benefits for inpatient stays will be reduced by $200.
- Benefits for doctor fees will be reduced by 25%.

You can also connect with Anthem to:

- Find a provider in the Anthem Century Preferred Network
- Resolve insurance claim and billing issues
- Ask questions about preventive and/or diagnostic care
- Get general health information

Urgent Care & Telehealth (YNHHS Medical Plan)

WHAT YOU NEED TO KNOW

Can't wait to see a doctor? Urgent care and telehealth services help you quickly connect with affordable care.

Urgent Care

When you need immediate care for an illness or injury, you can visit the nearest YNHHS walk-in facility or a PhysicianOne Urgent Care center. To locate an urgent care center close to you, visit HRConnect (ynhhs.org/hrconnect) and search for urgent care.

You'll pay a $25 copay when visiting a YNHHS facility, and you'll pay more if you use other providers.

Telehealth

Telehealth is an ideal alternative for immediate treatment of an illness or injury when you can't get to a doctor's office or urgent care center.

You and your covered family members can visit a doctor virtually, wherever you are, whenever you need care—via phone, tablet, or computer. If you need medication, the doctor can even send a prescription to your pharmacy (within Connecticut, New York, Massachusetts, and Rhode Island).

Use the telehealth services below to connect to care outside the usual office hours. **Telehealth is not an alternative to emergency care for a life-threatening condition.**

OnDemand

See one of our own Northeast Medical Group (NEMG) providers weekdays from 7 a.m. to 7 p.m. ET, excluding holidays. To get started, download the MyChart mobile app.

The NEMG providers you see OnDemand can:

- Diagnose symptoms
- Order testing
- Prescribe medication
- Send prescriptions to the pharmacy of your choice in Connecticut, New York, Massachusetts, and Rhode Island.

OnDemand does not cover pediatric services. Find more information about OnDemand at HRConnect (ynhhs.org/hrconnect).

How It Works

1. Register with MyChart online at ynhhs.org/ondemand or through the mobile app.
2. Schedule your OnDemand visit. You'll get reminder emails, phone calls, and app pushes to remind you of your upcoming visit.
3. Complete e-Checkin on the mobile app or website 15 minutes before your visit. You'll answer questions about your medical history and insurance coverage.
4. Pay for your visit with a credit card, debit card, or your HSA Bank Flexible Spending Account debit card.
5. Join a virtual waiting room, where a medical assistant will greet you and confirm your information.
6. Visit your OnDemand doctor.
7. After your appointment, find a summary of your visit in the MyChart app.

When you or your child can't wait for care

LiveHealth Online is there for you 24/7/365. Pediatric services are not covered by OnDemand.
Call 888-548-3432.

LiveHealth Online

For pediatric services, or to see a board-certified doctor after hours, on weekends and holidays, and when you're out of state, visit LiveHealth Online (livehealthonline.com/), download the mobile app, or call **888-548-3432**.

Prescription Drugs (YNHHS Medical Plan)

WHAT YOU NEED TO KNOW

You automatically have prescription drug coverage when you enroll in the YNHHS Medical Plan. You can fill covered prescriptions at participating CVS retail pharmacies, through mail order, or through YNHHS Outpatient Pharmacy Services.

Need to fill a prescription?

Find a participating pharmacy near you.
Connect with a local pharmacy: cvs.com/store-locator/landing

Filling Your Prescription

Your prescription will be covered only if it's filled at a participating pharmacy. To fill 30-day supply prescriptions, just present your prescription and CVS Caremark prescription drug card at a pharmacy in the CVS Caremark network. To fill a maintenance medication, you must use a CVS retail pharmacy, mail order, or visit a YNHHS Outpatient Pharmacy. For specialty medications, you'll need to use mail order or specialty pharmacy services, as described below.

In an emergency or if you're out of state and can't get to a participating pharmacy, you'll pay out of pocket and then file a claim for reimbursement from CVS Caremark.

Pay nothing for certain preventive drugs

The Affordable Care Act (ACA) makes many prescription medications, vaccines, and supplements—including contraceptives and statins—available to you at no cost.
No-Cost Preventive Drug List: caremark.com/portal/asset/NoCost_Preventive_List.pdf

When you're covered by the YNHHS Medical Plan, the out-of-pocket maximum is the most you'll pay out of pocket for medical care and prescription drugs.

When a generic is available and you or your doctor chooses a brand-name drug, you'll pay the brand-name coinsurance—plus the difference in cost between the two medications.

Save on Maintenance Drugs

For medications you take on an ongoing basis, you'll use the CVS Caremark Maintenance Choice program to get refills at a lower copay for a larger supply. With CVS Maintenance Choice, you get up to two 30-day fills at a retail pharmacy before you'll need to use CVS Caremark mail service (https://info.caremark.com/mailservice) or a CVS Pharmacy for 90-day fills.

What You Pay for Fills

What you'll pay depends on the type of medication and the amount prescribed. When the cost of a drug is less than the minimum copay, you'll pay the lower amount.

Tier 1: Generic

- 30-day supply: $10 copay
- 90-day supply through CVS Maintenance Choice: $20 copay

Tier 2: Brand name

- **30-day supply:** 20% coinsurance ($35 minimum, $80 maximum) if the drug is on the list of preferred brand drugs (the formulary)
- **90-day supply through CVS Maintenance Choice:** 20% coinsurance ($70 minimum, $150 maximum) if the drug is on the list of preferred brand drugs (the formulary)

Tier 3: Non-preferred brand

- **30-day supply:** 40% coinsurance ($55 minimum, $120 maximum) if the drug isn't on the list of preferred brand drugs (the formulary)
- **90-day supply through CVS Maintenance Choice:** 40% coinsurance ($110 minimum, $230 maximum) if the drug isn't on the list of preferred brand drugs (the formulary)

Tier 4: Specialty

Up to a 30-day supply only through YNHHS Outpatient Pharmacy Services.

- Generic and brand name: $20 copay

For certain high-cost specialty drugs not available through Outpatient Pharmacy Services or the Apothecary & Wellness Center, you'll use CVS Specialty Pharmacy. These medications are subject to 40% coinsurance (up to $150 generic, $200 brand name).

Preauthorization and Other Special Circumstances

Compounded Medications

Some prescriptions, including compounded drugs, require preauthorization from CVS Caremark before they can be filled. Your pharmacist will let you know if your doctor needs to make that call.

Breast Cancer Drugs

If you're taking raloxifene (brand name: Evista) or tamoxifen (brand name: Noladex) for primary prevention of breast cancer, these generics may be available at no cost to you through the preventive provisions of the Affordable Care Act. To learn if you qualify, your doctor will need to complete the Preventive Services Zero Cost Sharing Form and fax it to CVS Caremark.

Step Therapy Program

The step therapy program requires you to try one or two generic equivalents before the brand-name drug will be covered.

Drug classes included in this program include medications that treat high cholesterol, high blood pressure, gastrointestinal disorders (GERD, for instance), sleep disorders, depression, and other conditions.

Drugs and Supplies not Covered

The following drugs and medical supplies are not covered by the plan:

- Medical devices and appliances
- Experimental drugs
- Drugs whose sole purpose is to promote or stimulate hair growth
- Retin A (for those over age 28)
- Weight-loss drugs
- Immunization agents, biological sera, blood or blood plasma
- Infertility medications
- Most over-the-counter drugs, vitamins, and nutritional supplements
- Ostomy supplies

High Deductible Health Plan (HDHP)

You have two High-Deductible Health Plan (HDHP) options: the HDHP with Health Savings Account (HSA), or the HDHP with Healthcare Reimbursement Account (HRA). Both plans are administered by Anthem Blue Cross and Blue Shield. You can select the HDHP with HRA only if you have Medicare or TRICARE. With both plans, you pay the full cost of care until you meet your annual deductible. Your HSA or HRA can help you cover those costs.

How the Plans Work

Your medical plan is designed to help keep you and your family healthy. Used in tandem with your other benefits—including dental and vision coverage and services offered through the integrated employee assistance and work/life program—it's also here to support you when you need care.

You may choose to waive medical coverage if you're covered by another plan or your spouse is a YNHHS employee.

Under both HDHP plans:

- Your coverage is identical.
- You pay nothing for preventive care—including some preventive tests and prescription medications—when you use network providers.
- You pay the full cost of care until you meet your annual deductible, after which the plan begins to share costs with you.
- You pay discounted rates when you use providers and facilities in the Yale New Haven Health System and Anthem PPO network.
- You have mental health and substance abuse benefits.
- Special rules apply when you or your covered dependents are covered by more than one plan.
- There's a combined annual deductible for medical and prescription services. Until the deductible is met, your eligible medical and prescription drug costs are applied against the deductible.

The difference between the plans? Only the account that comes with them—the HSA or HRA.

Health Savings Account

The Health Savings Account (HSA) is a special account that you contribute to on a pretax basis through payroll deductions. Your employer contributes to it, too. You can use the money in your HSA to cover your health care expenses until you reach your annual deductible and the plan begins to share those costs with you. **The HSA is not available to you if you are currently enrolled in Medicare or TRICARE.**

When you enroll for the HDHP with HSA, you will receive a welcome packet from HSA Bank, our HSA administrator. Follow the instructions to open your account.

After you meet your deductible, you can use your HSA to cover any coinsurance.

- For 2021, you can contribute up to $3,600 in your HSA if you have individual coverage and $7,200 if you're covering others, too. And if you're 55 or older, you can contribute an additional catch-up contribution of $1,000. Keep in mind your employer's contribution, if any, when making your election. Total contributions to your account cannot exceed these IRS maximums.
- Your HSA contributions reduce your taxable income.
- Any unused funds roll over year after year, earning interest along the way.
- The money in your HSA is yours to use forever on qualified health expenses—even if you change employers or health plans, or retire.
- Once your balance reaches $1,000, you have the opportunity to invest it for potential growth.

Note: You also have the option of opening your HSA at a financial institution of your choice. However, unlike an account opened with HSA Bank, you will not be able to fund your HSA through direct payroll contributions, nor will you receive your employer's contribution.

Healthcare Reimbursement Account

The Healthcare Reimbursement Account (HRA) is a special account to which your employer contributes to help you cover the cost of your health care expenses. You can use these funds to cover your costs as you reach your annual deductible. **The HRA is available only to employees enrolled in Medicare or TRICARE.**

- As you receive services throughout the year, you pay out of pocket for expenses like coinsurance, copays, and other services, and then get reimbursed from your HRA up to the amount of your existing balance.
- Once you've met your annual deductible, you may pay coinsurance for the care you receive; the plan will cover the rest.
- You can use the HRA only while you are enrolled in this plan. You cannot take the money with you if you change plans or employers.
- You cannot contribute to your HRA.

How much you pay depends on the provider or facility you choose:

Anthem PPO Providers

When you choose to receive care from an Anthem Century Preferred Network provider:

- You'll need to meet your annual deductible ($2,000 individual/$4,000 family) before the plan begins to share the cost of your care.
- After you meet your deductible, you'll pay 20% coinsurance for care until you reach your annual out-of-pocket maximum.
- Once you meet your annual out-of-pocket maximum, the plan will pay 100% of covered expenses through that calendar year.

To find a provider in the Anthem Century Preferred Network, visit the Anthem website (http://anthem.com/) or call **888-266-2896**.

Out-of-Network Providers

When you use a provider or facility that is not in the Anthem Century Preferred Network:

- You'll pay the most for care.
- Anthem will pay a maximum allowable amount (MAA).
- You will be responsible for costs up to your annual deductible, coinsurance, and any difference between the MAA and the amount billed by the provider.
- You'll need to file a claim for the care to be covered. Payments will be made directly to the provider unless you submit a bill showing you've paid it already.

What You Pay for Care

Below is a summary of how certain services are covered. For a more complete list and any limitations, visit HRConnect to view the summary plan description (SPD), which will be available on January 1, 2021.

Plan Feature	Anthem PPO Provider	Out-of-Network Provider
Annual Deductible	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000
Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $4,000 Family: $8,000
Member Coinsurance After Deductible	0% after deductible	30% after deductible
Preventive Care Exams	0% deductible waived	30% after deductible
Office Visits	0% after deductible	30% after deductible
Diagnostic Services Performed in Hospital (Lab, x-ray, MRI, PET, CAT scan, nuclear cardiology)	0% after deductible	30% after deductible
Rehabilitation Therapy Performed in Hospital[1] (Physical, speech, occupational, chiropractic, cardiac rehab)	0% after deductible	30% after deductible
Emergency Care (Emergency room; copay waived if admitted)	$100 copay after deductible	$200 copay after deductible
Urgent Care	0% after deductible	30% after deductible
Ambulance Services	0% after deductible	30% after deductible
Telehealth Anthem PPO Providers: LiveHealth Online and YNHHS OnDemand	$49 after deductible	n/a
Outpatient Surgery Performed in Hospital Ambulatory Care Center[2]	0% after deductible	30% after deductible
Inpatient Surgery[3] (Semi-private room and board)	0% after deductible	30% after deductible
Outpatient Mental Health/Substance Abuse Services Performed in Office[4]	0% after deductible	30% after deductible
Inpatient Mental Health/Substance Abuse Services[5]	0% after deductible	30% after deductible

Plan Feature	Anthem PPO Provider	Out-of-Network Provider
Skilled Nursing Facility[6]	0% after deductible	30% after deductible
Durable Medical Equipment[7]	0% after deductible	30% after deductible

[1] Physical, speech, and occupational therapy visits are limited to a combined total of 60 visits per member per calendar year. For physical therapy and occupational therapy, prior authorization is required after the first visit. Chiropractic services are limited to 12 visits per member per calendar year.

[2] Hospital or surgical center facility charges only.

[3] Room and board, lab work, medical supplies, and other hospital ancillary services.

[4] The Employee and Family Resources (EFR) program provides up to six (6) confidential counseling sessions at no cost to you.

[5] Inpatient rehabilitative services are limited to 100 days per member per year.

[6] Skilled nursing facility services are limited to 100 days per calendar year.

[7] You must use a participating provider to be covered for durable medical equipment and prosthetic devices.

To see employee premium contributions for the medical plan, visit ynhhsbenefits.com.

When to Connect with Anthem

For a medical stay and/or service preauthorization, call **800-238-2227** (in Connecticut) or **800-248-2227** (out of state). For behavioral health or substance abuse stays, call **800-934-0331**.

Before receiving any of the following services, you must call Anthem for preauthorization. Otherwise, your benefits will be reduced.

- **Inpatient stays** in a hospital, skilled nursing facility, hospice facility, subacute care or acute rehabilitation facility, or a behavioral health or substance abuse treatment center (CALL at least 24 hours before the start of your stay)
- **High-cost diagnostic imaging services** prescribed by an out-of-network provider
- **Organ/tissue transplants,** including evaluation, donor search, organ procurement/tissue harvest, or transplant

For admissions following emergency or urgent care, you, your representative, or your doctor must call Anthem within 48 hours of admission.

If you do not precertify for the services above:

- Benefits for inpatient stays will be reduced by $200.
- Benefits for doctor fees will be reduced by 25%.

You can also connect with Anthem to:

- Find a provider in the Anthem Century Preferred Network
- Resolve insurance claim and billing issues
- Ask questions about preventive and/or diagnostic care
- Get general health information

Urgent Care & Telehealth (HDHP)

WHAT YOU NEED TO KNOW

Can't wait to see a doctor? Urgent care and telehealth services help you quickly connect with affordable care.

Urgent Care

When you need immediate care for an illness or injury, you can visit any Anthem PPO urgent care center.

Telehealth

Telehealth is an ideal alternative for immediate treatment of an illness or injury when you can't get to a doctor's office or urgent care center.

You and your covered family members can visit a doctor virtually, wherever you are, whenever you need care—via phone, tablet, or computer. If you need medication, the doctor can even send a prescription to your pharmacy (in Connecticut, New York, Massachusetts, and Rhode Island).

Use the telehealth services below to connect to care outside the usual office hours. **Telehealth is not an alternative to emergency care for a life-threatening condition.**

OnDemand

See one of our own Northeast Medical Group (NEMG) providers weekdays from 7 a.m. to 7 p.m. ET, excluding holidays. To get started, download the MyChart mobile app.

The NEMG providers you see OnDemand can:

- Diagnose symptoms
- Order testing
- Prescribe medication
- Send prescriptions to the pharmacy of your choice in Connecticut, New York, Massachusetts, and Rhode Island.

If you've already met your annual deductible, you'll pay a $49 copay to use OnDemand. OnDemand does not cover pediatric services. Find more information about OnDemand at HRConnect.

How It Works

1. Register with MyChart online at ynhhs.org/ondemand or through the mobile app.
2. Schedule your OnDemand visit. You'll get reminder emails, phone calls, and app pushes to remind you of your upcoming visit.
3. Complete e-Checkin on the mobile app or website 15 minutes before your visit. You'll answer questions about your medical history and insurance coverage.
4. Pay for your visit with a credit card, debit card, or your HSA Bank Flexible Spending Account debit card.
5. Join a virtual waiting room, where a medical assistant will greet you and confirm your information.
6. Visit your OnDemand doctor.

7. After your appointment, find a summary of your visit in the MyChart app.

When you or your child can't wait for care

LiveHealth Online is there for you 24/7/365. Pediatric services are not covered by OnDemand.
Call 888-548-3432.

LiveHealth Online

If you've already met your annual deductible, you'll pay a $49 copay to use LiveHealth Online. You can pay with a credit or debit card, including your HSA debit card or your FSA debit card. Be sure to provide your Anthem ID card information, so your claim is processed as an office visit.

For pediatric services, or to see a board-certified doctor after hours, on weekends and holidays, and when you're out of state, visit LiveHealth Online (livehealthonline.com), download the mobile app or call **888-548-3432**.

Prescription Drugs (HDHP)

WHAT YOU NEED TO KNOW

Until you meet your annual deductible, you'll pay the full cost of your prescription drugs. Those costs are applied against your deductible, and you can use funds in your HSA or HRA to cover them.

You can fill covered prescriptions at participating CVS retail pharmacies or through CVS Caremark mail service. You will pay the actual cost of your prescription, as negotiated between CVS Caremark and the pharmacy.

Need to fill a prescription?

Find a participating pharmacy near you.
Connect with a local pharmacy: www.caremark.com/

Filling Your Prescription

Short-Term Medications

You can fill up to a 30-day supply of a prescription at more than 5,000 participating pharmacies in the Connecticut, New York, and New Jersey area (64,000 nationwide), including major pharmacy and supermarket chains and most independent drug stores. To determine if a pharmacy is part of the CVS Caremark network, view the online pharmacy provider directory at caremark.com.

When you fill a short-term prescription, such as a 30-day supply, at a participating pharmacy, simply present the prescription and your CVS Caremark prescription drug card.

In an emergency or if you're out of state and can't get to a participating pharmacy, you'll pay out of pocket and then file a claim for reimbursement from CVS Caremark.

Pay nothing for certain preventive drugs

The Affordable Care Act (ACA) makes many prescription medications, vaccines, and supplements—including contraceptives and statins—available to you at no cost.

When a generic is available and you or your doctor chooses a brand-name drug instead, you'll pay the brand-name copay—plus the difference in cost between the two medications.

What You Pay for Fills

The High-Deductible Health Plans have a combined annual deductible for medical and prescription drug services. You'll pay the full cost of services until you meet your deductible; for prescription drugs, you'll pay the actual cost of your medication, as negotiated between CVS Caremark and the pharmacy.

Under these plans, the most you'll pay out of pocket for medical care and prescription drugs in any calendar year is $3,000 per individual or $6,000 per family.

How much you'll pay for your prescription depends on the type of medication and the amount prescribed. When the cost of a drug is less than the minimum copay, you'll pay the lower amount.

Tier 1: Generic

- **30-day supply:** $10 copay after deductible
- **31- to 90-day supply:** $10 copay after deductible through CVS Caremark mail service (info.caremark.com/mailservice)

Tier 2: Brand Name

- **30-day supply:** $25 copay after deductible, if the drug is on the list of preferred brand drugs (the formulary)
- **31- to 90-day supply:** $50 copay after deductible through CVS Caremark mail service (info.caremark.com/mailservice)

Tier 3: Non-Preferred Brand

- **30-day supply:** $40 copay after deductible, if the drug isn't on the list of preferred brand drugs (the formulary)
- **31- to 90-day supply:** $80 copay after deductible through CVS Caremark mail service (info.caremark.com/mailservice)

A Word About Specialty Drugs

Certain high-cost specialty drugs are subject to the Advance Control Specialty Formulary. This formulary includes specialty generics and clinically effective brand therapies, and combines other specialty programs, such as Specialty Guideline Management to ensure proper utilization. For the most current formulary listing, visit the Caremark website (caremark.com/) or call CVS Caremark customer service at **877-636-0406**.

Preauthorization and Other Special Circumstances

Compounded Medications

Some prescriptions, including compounded drugs, require preauthorization from CVS Caremark before they can be filled. Your pharmacist will let you know if your doctor needs to make that call. Compounded drugs are covered as Tier 3 medications.

Breast Cancer Drugs

If you're taking raloxifene (brand name: Evista) or tamoxifen (brand name: Nolvadex) for primary prevention of breast cancer, these generics may be available at no cost to you through the preventive provisions of the Affordable Care Act. To learn if you qualify, your doctor will need to complete the Preventive Services Zero Cost Sharing Form and fax it to CVS Caremark.

Drugs and Supplies Not Covered

The following drugs and medical supplies are not covered by the plan:

- Medical devices and appliances
- Experimental drugs
- Drugs whose sole purpose is to promote or stimulate hair growth
- Retin A (for those over age 28)
- Weight-loss drugs
- Immunization agents, biological sera, blood or blood plasma
- Infertility medications
- Most over-the-counter drugs, vitamins, and nutritional supplements

Ostomy supplies

Health Care FSA

WHAT YOU NEED TO KNOW

A Health Care Flexible Spending Account (FSA) helps you set aside money to pay for health care expenses you'll have during the year. The pluses: You contribute pretax income, so you're paying no taxes on your contributions—plus, your contributions reduce your taxable income. The catch: You need to budget carefully, since you'll have to forfeit any unused balance over $550.

How It Works

When you elect your benefits as a new employee or during annual open enrollment, you choose your FSA contribution level for the calendar year (up to $2,750 in 2021).

Plan carefully! You can carry over up to $550 in unused funds to the next plan year, but you'll forfeit anything over that. You have until March 31, 2021, to submit your 2020 claims through PayFlex.

For example, as of December 31, **2020**, you have $600 of unused FSA funds. You can carry over $550 for use by December 31, **2021**. The remaining $50 must be used for **2020** expenses. You have until March 31, **2021**, to submit them for reimbursement. If you don't submit 2020 claims by March 31, 2021, the $50 is forfeited.

Limited-Purpose FSA for the HDHP Medical Plan. If you're enrolled in the HDHP with Health Savings Account (HSA) and want pretax options for covering out-of-pocket dental and vision expenses, you can open a Limited-Purpose FSA. This type of FSA covers out-of-pocket dental and vision expenses only.

Full FSA for the YNHHS Medical Plan or if you waive medical coverage. You can enroll in the full FSA if you want pretax options for covering medical, prescription drug, dental, and/or vision out-of-pocket expenses.

If you enroll in the YNHHS Medical Plan or you waive medical coverage, and you elect a Health Care FSA, your pretax paycheck contributions are deposited directly into your FSA, which is administered by HSA Bank.

You can use your FSA to pay for eligible expenses, including:

- Copays and coinsurance
- Prescription drugs and over-the-counter medications (with a doctor's prescription)
- Medical equipment, like crutches, and supplies such as bandages
- Vision care, like eyeglasses and contact lenses
- Dental expenses, such as fillings and braces

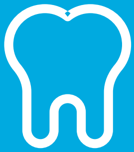
When you have eligible expenses, you can use your FSA debit card to pay for them. Or, you can submit receipts and file a claim for reimbursement.

Please keep in mind that you cannot reimburse yourself for the same expense with money from both your HRA and FSA.

Managing Your Health Care FSA

You set up and manage your FSA on the HSA Bank website or via the mobile app. Then, you can upload receipts and submit claims, pay providers, and track your account balance and transactions.

You have until March 31 of the following year to submit receipts for reimbursement.



Dental Benefits

WHAT YOU NEED TO KNOW

The Cigna Dental Option 1 (Basic) plan covers all your dental needs, from routine exams and cleanings to major services like bridgework and crowns and orthodontia. Although you may see any dentist you like, when you visit a network dentist, you'll pay less and you won't have to file a claim.

Find a participating dentist

The Cigna website makes it simple to locate a participating dentist in your area.
Connect with a network dentist: hcpdirectory.cigna.com/

Plan Features

The Cigna Dental Option 1 plan features:

- A nationwide network of Cigna dentists
- Discounted rates for using participating Cigna network dentists
- Preventive services at no cost to you
- Coverage for restorative services

You can also choose to waive dental coverage.

Know Before You Go

Before you sit down for a procedure that will cost more than $200, contact Cigna to request a pretreatment review of benefits. That way, you'll know how much the plan will cover and how much you'll need to pay.

What You Pay for Care

Plan Feature	**In-Network**	**Out-of-Network***
Annual Deductible**	Individual: $50 Family: $150	Individual: $50 Family: $150
Individual Maximum Calendar-Year Benefit** (excludes orthodontia)	$1,200	$1,200
Preventive & Diagnostic Care Services (no deductible) includes routine exams, cleanings, x-rays, sealants, and other services	$0	$0

Plan Feature	In-Network	Out-of-Network*
Basic Restorative Care such as fillings, oral surgery, extractions, root canals, periodontics, and repairs to dentures, bridges, and crowns	20% coinsurance after deductible	20% coinsurance after deductible
Major Restorative Care such as dentures, bridges, crowns, and implants	40% coinsurance after deductible	40% coinsurance after deductible
Orthodontia	40% coinsurance after deductible Lifetime maximum benefit (per person):** $1,000	40% coinsurance after deductible Lifetime maximum benefit (per person):** $1,000

*All plan deductibles and maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

For additional details about covered services, including what the plan pays if you use an out-of-network provider or facility, exclusions, and limitations, visit HRConnect to view the Cigna Dental Plan Option 1 summary plan description (SPD).

If You Use an Out-of-Network Dentist

- You may pay more for services because non-participating dentists have not negotiated fee discounts with Cigna.
- You may need to pay the dentist yourself and then submit a claim to be reimbursed by Cigna.

If you need to submit a dental claim yourself, ask your dentist for a standard American Dental Association claim form.

Vision Benefits

WHAT YOU NEED TO KNOW

The Vision Plan from Vision Service Plan (VSP) covers an annual eye exam and a pair of glasses or contact lenses every calendar year.

Find a participating doctor

You'll maximize your benefits and pay less out of pocket when you see a VSP doctor.
Connect with a network doctor: www.vsp.com/

Plan Features

The Vision Plan offers in- and out-of-network benefits. The chart below shows what the plan pays for care.

Plan Feature	In-Network Coverage	Out-of-Network Coverage
Eye exam (every calendar year)	100% after $10 copay	Up to $50
Corrective lenses (every calendar year)	100% after $10 copay Standard progressive: $50 Premium progressive: $80–$90 Custom progressive: $120–$160	Single vision: Up to $50 Lined bifocal and trifocals: Up to $75 Trifocals: Up to $100 Progressive: Up to $75
Frames (every calendar year)	Up to $170, plus 20% discount after $25 copay	Up to $70
Contact lenses (every calendar year)	$125 allowance, plus up to $60 toward contact lens exam	Up to $105 when you choose contacts instead of glasses

For complete details about covered expenses, exclusions, and limitations, visit HRConnect to review the Vision Plan summary plan description (SPD) for your vision plan.

Employee & Family Resources

WHAT YOU NEED TO KNOW

Because life doesn't come with a playbook, the Employee and Family Resources (EFR) program, administered by Beacon Health Options, is here for you 24/7, at **no cost**. EFR connects you to the confidential support, referrals, information, and other resources you need to get you through the good and not-so-good times.

Got more than you can handle?

Call toll-free: 24/7 **877-275-6226**

Program Features

EFR is our employee assistance and work/life program, and it provides free, confidential services and resources to you and members of your family, 24/7.

What can you use it for?

- Get help dealing with relationship issues, anxiety and depression, substance abuse, and more.
- Have up to six free sessions with a licensed counselor.
- Get referrals to legal and financial services.
- Locate the perfect summer camp for your kids, or an adult day care provider to watch an elderly parent while you're at work.
- Find resources, like videos, articles, and webinars covering a variety of topics, on the Beacon Health Options website (www.achievesolutions.net/ynhhs).

Get help via phone, in person, or online.

Consider reaching out to a Beacon counselor for up to six free visits before accessing your Anthem behavioral health benefits, which require a copay.

*living***wellCARES**

WHAT YOU NEED TO KNOW

Multiple medications. Doctor appointments. Screenings and tests. Lifestyle adjustments. There's a lot involved in managing a chronic condition. *living***wellCARES** offers free, confidential chronic care management to employees and family members enrolled in the YNHHS Medical Plan.

Need support for a healthier lifestyle?

Even if you're not managing a chronic condition, you can tap the specially trained coaches at *living***wellCARES** for help creating healthy new habits and reducing your risk factors.

What's in It for You

Ongoing, one-on-one support to help manage your care plan. Even better—you may save on what you pay for condition-related medication and supplies.

How It Works

Specially trained nurses partner with you and your doctors. You speak with them often, either by phone, virtually, or in person.

They help you schedule appointments, manage medications, and support the changes you may need to make to manage your health condition successfully. Best of all, they offer the inspiration you and your family need to achieve your wellness goals.

How to Participate

Unless you opt out during Open Enrollment, you may receive an invitation to participate if your recent medical claims reflect a diabetes or high blood pressure diagnosis. You can also enroll on your own. Either way, participating is confidential and voluntary. Your personal health information is protected by HIPAA; neither management nor Human Resources have access to that information.

To enroll, call **888-533-3742**. The *living***wellCARES** team of care coordinators and health coaches will set up a time to meet that's convenient for you.

Maternity Support, Too

If you or your spouse/partner is expecting, you'll have access to these maternity resources when you enroll in *living***wellCARES**:

- A free Medela breast pump
- Free nutrition classes—whether you're expecting or thinking of becoming pregnant, simply send a quick email to sign up today

Quit For Life

WHAT YOU NEED TO KNOW

You can connect with the resources you need to quit tobacco forever through the American Cancer Society's Quit For Life® program. You and your covered dependents can participate in the program at **no cost** when you're enrolled in the YNHHS Medical Plan.

Quit For Life provides free round-the-clock, confidential, telephone-based coaching. No-cost nicotine replacement therapy is also available, with counseling. If you need tobacco-cessation prescription drugs (e.g., Chantix), they're covered at the Tier 1 generic level through your YNHHS prescription drug plan.

You can enroll at Quit For Life or by calling **866-784-8454**.

Education Support for Children

WHAT YOU NEED TO KNOW

When your child needs extra learning support or help taking that next educational leap, connect with the experts at Bright Horizons for free guidance and resources that address their unique needs.

Special Needs Help

If your child is having trouble focusing, lagging behind developmentally, or struggling with social skills, you'll find personalized help from a compassionate Bright Horizons Special Needs™ advisor. You can also watch webinars to learn what you need to successfully guide and advocate for your child's education.

College Advising

For students preparing to apply to college, there's College Coach. Offering expert guidance on the college admissions and financial aid process, college admissions consultants can help your child identify best-fit schools and review college admission essays.

To get started, visit Bright Horizons (clients.brighthorizons.com/ynhhs).

Autism Spectrum Disorders

WHAT YOU NEED TO KNOW

Through Anthem's autism spectrum disorders (ASD) program, a team of dedicated clinicians and case managers guides you and your family through the complex care system while addressing your family's unique needs. You're eligible for this program only if you and your covered dependents are enrolled in the YNHHS Medical Plan.

Your YNHHS medical plan includes coverage for applied behavior analysis (ABA) therapy.

The ASD program includes:

- **Clinical review of your child's applied behavior analysis.** This ensures your child receives the right care from the right provider at the right time.
- **Coordination of care by case managers.** They develop a customized care plan that identifies available resources, secures access to care you may be missing, and facilitates collaboration among treatment providers.
- **Connection to community resources and support.** You need this to build a strong foundation of care and support for your family.

To learn more, call **844-269-0538**.

Dependent Care FSA

WHAT YOU NEED TO KNOW

Setting aside pretax dollars in a Dependent Care Flexible Spending Account (FSA) can help you save on child or adult day care expenses. The Dependent Care FSA covers eligible dependent care expenses, including preschool, summer camp, before- and after-school programs, and child and adult day care while you work.

How It Works

When you elect your benefits as a new employee or during annual open enrollment, you choose your FSA contribution level for the calendar year (up to $5,000 if you and your spouse file taxes jointly; $2,500 if you file separately).

You'll need to elect your contribution level during open enrollment each year (as long as you have an FSA), because FSA elections don't roll over from year to year.

Your pretax paycheck contributions are deposited directly into your Dependent Care FSA, which is administered by HSA Bank.

Managing Your Dependent Care FSA

You set up and manage your FSA on the HSA Bank website or via the mobile app. You have the option to pay dependent care expenses directly from your FSA using your HSA Bank debit card, or submit receipts and be reimbursed for expenses you pay out of pocket.

You have until March 31 of the following year to submit receipts for reimbursement.

Contacts

Enrolling & Benefits Information

HRConnect
Monday–Friday,
7:30 a.m. to 5 p.m. ET
844-543-2147
203-200-3838 (fax)
ynhhs.org/hrconnect

Medical Benefits

Anthem Blue Cross and Blue Shield
844-963-0447 (YNHHS Medical Plan)
844-412-2983 (HDHP Plans)
www.anthem.com/

COBRA

bswift
866-365-2413
Email

Telehealth

LiveHealth Online
888-548-3432
Website

OnDemand

833-483-5363
Website

Prescription Drug Benefit

800-776-1355
800-294-5979 (Preauthorization)
800-237-2767 (Specialty Pharmacy)
Website

YNHHS Outpatient Pharmacy Services (YNHHS Medical Plan)

844-881-0043
203-230-0679 (fax)
Website

Dental Benefit

Cigna Dental Plan
800-244-6224
Website

Vision Benefit

Vision Service Plan (VSP)
800-877-7195
Website

Employee & Family Support Benefits

Employee assistance and work/life program
Beacon Health Options
877-275-6226
Website

Care coordination, maternity resources, wellness coaching

*living*wellCARES
888-533-3742
Website

Smoking cessation (YNHHS Medical Plan)

Quit For Life
American Cancer Society
866-784-8454
Website

Education support for children

Bright Horizons

For children who need extra help
Website

For individual advising
Website

College Coach
888-527-3550
ynhh@getintocollege.com
Website
Employer Username: YNHHS
Password: Benefits4You

Autism Spectrum Disorders (ASD) Program (YNHHS Medical Plan)

844-269-0538

Voluntary Benefits

YNHHS Voluntary Benefits
866-874-2837
Website

Financial Benefits

Dependent Care FSA
Health Care FSA
HSA Bank
800-357-6246
866-357-6232 (Spanish)
Website

PayFlex (for 2020 FSA claims)
844-729-3539
Website

Family/medical leave and long-term disability

The Hartford
888-301-5615
Website

Retirement 403(b)

Fidelity
800-343-0860
Website

Tuition assistance

EdAssist
844-266-1531
Website

Terms to Know

Claims Administrator

The insurance company or third party that reviews, approves, and pays benefits claims.

Coinsurance

Once you've met your annual deductible, coinsurance is the percentage of costs you'll pay out of pocket for services covered by your plan (until you meet your out-of-pocket maximum for the calendar year).

Compounded Drugs

Customized medications developed for an individual based on a doctor's prescription. Prescriptions for compounded medications will require prior authorization from CVS Caremark. They will be covered as Tier 3 medications. You can get 30-day fills at a CVS retail pharmacy; larger fills are available through the CVS Caremark Maintenance Choice program.

Copay

The fixed amount you pay for an in-network service.

Deductible

The amount you must pay for covered health services each year before the plan begins to pay its share of costs. The deductible may not apply to some services, including preventive care, in-network doctor visits, and services billed by a YNHHS facility.

Dependent Children Over Age 26

You can continue coverage for your fully handicapped dependent child past the child's 26th birthday only if you submit proof within 31 days of the child's 26th birthday that the child is disabled. Coverage will end in the following situations: when your child is no longer handicapped, if you do not provide proof of continued disability, if you fail to have any required exam for that child, or when dependent coverage terminates for any other reason.

Diagnostic Care

Specific care and/or procedures that help a doctor investigate symptoms or test results and make a diagnosis.

Example: You typically receive preventive care during an annual checkup. If a preventive screening yields an abnormal result, you may receive diagnostic care to determine why.

Health Reimbursement Account

An account offered in conjunction with the HDHP for employees enrolled in Medicare or TRICARE. Your employer contributes to your HRA, and you can use these funds to cover the cost of your care until you meet your annual deductible. At that point, the plan will begin to share the cost of your care. Unlike an HSA, the HRA is not portable; you can't take it with you if you leave your employer or change medical plans.

Health Savings Account (HSA)

A special account that's typically paired with a high-deductible health plan (HDHP). You and/or your employer contribute to the account, and you can use these funds to cover qualified healthcare expenses, including your annual deductible, copays, and coinsurance. Annual contributions for individuals and families are set by the IRS; for 2021, you can contribute up to $3,600 if you have individual coverage, and up to $7,200 if you cover others, too. The money in your HSA is yours to use into retirement, even if you change plans or employers.

High-Deductible Health Plan (HDHP)

A health plan with a higher annual deductible than most PPO plans. It doesn't begin to share the costs for covered services until you meet the annual deductible. The annual deductible is $2,000 for individual coverage and $4,000 for family coverage (2 or more people). To help you cover these costs, you can use funds in the Health Savings Account (HSA) or Health Reimbursement Account (HRA) that's paired with your HDHP.

Example: The individual deductible for the High-Deductible Health Plan is $2,000. When two covered members of your family have each met their $2,000 deductible, the $4,000 family deductible for the year will have been met. After you meet the deductibles, the plan will pay its share of costs for all covered family members during that calendar year.

In-Network Provider

The facilities, providers, and suppliers that Anthem Blue Cross and Blue Shield has contracted with to provide health care services. The Westerly High-Deductible Health Plans use Anthem's National PPO Provider Network; the YNHHS Medical Plan offers two different in-network provider networks:

1. The Signature Network (YNHHS Medical Plan only) includes facilities owned by Yale New Haven Health, Yale Medicine, and Trinity New England. The Signature Clinician network includes our Signature PCPs and any specialist with privileges at a hospital owned by Yale New Haven Health. For a complete list of all the Signature Network facilities and providers, please visit HRConnect
2. Anthem Preferred Provider Organization (PPO) includes providers and facilities in Anthem's Century Preferred Network.

Maximum Allowable Amount (MAA)

The maximum amount that Anthem will pay for a covered service or the billed charge—whichever is lower. Applies to out-of-network services only.

Out-of-Network Provider

Any provider or facility that has not contracted with Anthem Blue Cross and Blue Shield and is not part of Anthem's Century Preferred Network. Anthem will pay up to the MAA for these services, and all claims will be subject to applicable deductibles and coinsurance.

Out-of-Pocket Costs

Any cost or fee that you pay for medical services, prescription drugs, or medical supplies. These include your annual deductible, and copays and coinsurance.

Out-of-Pocket Maximum

The most you will pay in a calendar year for medical or prescription drug expenses. Once the out-of-pocket maximum has been met, the play pays 100% of covered expenses for the covered person or family for the remainder of the calendar year, including copays and expenses that are applied toward the annual deductible.

The out-of-pocket maximum does not include benefit reductions due to failure to precertify, covered expenses paid at 100%, expenses exceeding the MAA, expenses not covered by the plan, or employee premium contributions.

Preferred Provider Organization (PPO)

Doctors, hospitals, and other providers who have agreed to negotiated fees with Anthem. Typically, you'll pay less than you would for services from a non-PPO provider.

Preventive Care

Screenings, annual checkups, and patient counseling to prevent illness, disease, and other health problems. Under the Affordable Care Act (ACA), all health plans must cover certain preventive health services at no cost to the patient. Some prescription drugs are also considered preventive under the ACA and are covered at 100%.

Primary Care Physician

A medical doctor who provides or coordinates health services for a patient. Primary care physicians are typically aligned with internal medicine, general or family medicine, and pediatrics practices.

Prior Authorization

A decision reached by your health plan—before services are performed or purchases are made—that a health care service, treatment plan, prescription drug, or durable medical equipment item is medically necessary. Your plan may require prior authorization for certain services, except in an emergency. Prior authorization is not a promise that your plan will cover the cost. Prior authorization for prescription drugs ensures medications are safe and being prescribed for FDA-approved uses.

Qualifying Life Event

A major life event—including a change in family size, marriage, divorce, or loss of current coverage—that allows you and/or eligible family members to enroll in or make changes to your existing health coverage. If you experience a qualifying life event, you must make the change within 31 days on our enrollment site.

Specialist

A physician who focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain symptoms and conditions.

Examples include allergist, cardiologist, dermatologist, orthopedist, podiatrist, ear/nose/throat, gastroenterologist, OB/GYN, ophthalmologist.

Voluntary Benefits

Products offered through an employer that the employer typically pays for at below-market rates. These can include life, disability, critical-illness, accident, homeowner's, auto, and pet insurance; ID theft protection; legal services; and other benefits.

Documents & Forms

All documents and forms can be accessed on HRConnect. You'll also find summary plan descriptions, summaries of material modifications, carrier claim forms, and more.